Optegra UK Limited

Optegra Manchester Eye Hospital

Inspection report

The Boulevard
Didsbury
M20 2EU
Tel:
www.optegra.com

Date of inspection visit: 24 May 25 May 26 May 31may
Date of publication: 15/08/2022

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

Our rating of this location improved. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment. Outcomes for patients were consistently better than expected when compared with other similar services. Staff gave patients pain relief when they needed it. Managers monitored the effectiveness of the service and opportunities to participate in benchmarking were actively pursued. The service recognised the importance of continuing development of staff skill, competence and knowledge as integral to ensuring safe care. Staff worked well together for the benefit of patients and supported them to make decisions about their care and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers. Feedback from patients was continually positive.
- The service planned care to meet the needs of local people with innovative approaches to providing person-centred pathways. People's individual needs and preferences were central to the delivery of tailored services. The service made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	Our rating of this service improved. We rated it as good because: • The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. • Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week. • Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers. • The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment. • Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and

Summary of findings

accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Outpatients

Good

Our rating of this service stayed the same. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

We rated this service as good because it was safe, effective, caring and responsive, and well led.

Summary of findings

Contents

Summary of this inspection

Background to Optegra Manchester Eye Hospital

Optegra Manchester Eye Hospital is operated by Optegra UK Limited.

The hospital treats privately funded and NHS funded ophthalmic patients. For its NHS patients, the hospital provides day case cataract surgery and age-related macular degeneration (AMD) treatments, primarily serving the communities of the Greater Manchester area, North and East Cheshire and East Lancashire.

The hospital also provides a range of day surgery procedures for private-fee paying patients, such as refractive laser eye surgery, lens exchange surgery and intraocular lens implant procedures.

The hospital is located in the West Didsbury area, approximately three miles from Manchester city centre. It occupies the ground floor of a four-storey multi-occupancy building with parking for patients available on-site.

Parking bays for people living with limited mobility are located close to the main entrance of the hospital; a ramp provides access to the main entrance for people using a wheelchair or those who are unable to use the steps.

The hospital has a registered manager who has been in post since April 2021.

Optegra Manchester Eye Hospital is registered to provide the following regulated activities:

- Diagnostic and screening procedures
- Surgical procedures
- Treatment of disease, disorder or injury

The hospital is registered to provide services to younger adults and older people; it does not treat anyone under the age of 18.

The main service provided by this hospital was surgery. Where our findings on surgery – for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the surgery service.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection.

There has been no never events, and one serious incident reported by the service in the last 12 months. There were no incidents of hospital acquired infections reported in the last 12 months.

This hospital was last inspected in July 2017 (report was published in November 2017) and was rated as Requires Improvement. This was because CQC identified breaches of Regulation 12 Safe care and Treatment, and Regulation 17 Good Governance. CQC issued requirement notices for improvement to the provider.

During the current inspection, CQC found that the hospital had made sufficient improvements and it is now compliant with both Regulation 12 and Regulation 17. No new breaches of regulation were found.

Summary of this inspection

How we carried out this inspection

We inspected this service using our comprehensive inspection methodology. The inspection was unannounced. We carried out the on-site inspection between 24 May 2022 and 26 May 2022.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

During the inspection visit, the inspection team:

- Inspected the day surgery and outpatient services, including the main premises, the treatment rooms and the theatre areas.
- We spoke with 18 staff including registered nurses, health care technicians, reception staff, consultants, an optometrist and senior managers such as the hospital manager and the regional head of clinical services (also the registered manager).
- Spoke with two surgical patients and six patients and two carers in outpatients.
- Looked at the training and recruitment files for four staff.
- Looked at eight sets of patient records.
- Looked at six medicines prescription and administration records.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Outstanding practice

There were elements of strong leadership which supported a constructive culture among staff, this had a positive impact on sickness levels.

Areas for improvement

Surgery and Outpatients:

We did not identify any areas for improvement as part of this inspection.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	Good	Good
Outpatients	Good	Inspected but not rated	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Surgery

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Are Surgery safe?

Good

Our rating of safe improved. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

All staff including medical, nursing, healthcare technician and administration staff received and kept up-to-date with their mandatory training. Training was delivered through a combination of eLearning and face to face training. The compliance rate for mandatory training for all hospital staff was 98.3%.

Mandatory training modules included topics such as conflict resolution, fire safety awareness, health and safety, infection prevention and control, safeguarding of children and adults, life support training and equality, diversity and human rights. The training was comprehensive and met the needs of patients and staff.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training. Mandatory and core clinical skills training records were stored centrally on the provider's national governance and quality reporting system.

All staff had access to the system with the level of access available to each staff member's system profile. The system alerted staff when each individual module was due to expire or when it was overdue. Senior managers had full oversight staff training records and completion rates.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Good

Surgery

The regional head of clinical services was trained to level 4 and there were three leaders in the hospital (hospital manager, outpatient manager and day surgery manager) who were trained to level 3 in safeguarding.

Staff received training specific for their role on how to recognise and report abuse. All eligible staff (100%) had completed level one and level two safeguarding adults training within the previous 12 months. For level one and level two safeguarding children training, all but two staff members (96.3%) eligible for the training had completed it within the previous two months.

Six staff were eligible for and had completed level three safeguarding adults and children training. The registered manager was the safeguarding lead for the hospital and had completed level four safeguarding adults and children training. Staff worked with external organisations (such as local authority safeguarding teams) to obtain advice or to escalate safeguarding concerns if needed.

The level of training was in line with current intercollegiate guidance for adults and children.

Staff we asked gave a range of examples of how to identify and protect patients at risk of significant harm, abuse, harassment and discrimination, including those with protected characteristics under the Equality Act. The hospital also achieved 100% compliance in 'Prevent' (anti-radicalisation) training for staff.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Information on how to raise concerns within the service and to external bodies (such as local authority safeguarding teams) was available for staff.

The hospital reported one safeguarding incident during the past 12 months. This was not directly attributable to the hospital and related to staff identifying concerns about the welfare of a patient and appropriate referral to the local authority safeguarding team.

Staff followed safe procedures for children attending the hospital. The hospital did not treat any patients under the age of 18, but staff recognised the need for such procedures as children may accompany a parent or relative for their appointment.

Cleanliness, infection control and hygiene

The hospital controlled infection risk well. It used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All areas of the hospital were visibly clean and had suitable cove-skirting flooring types and furnishings which were clean and well-maintained. The hospital sub-contracted the cleaning of all areas to an external cleaning provider under a service level agreement arrangement. The housekeeper had a schedule of works log which set out the specific areas to be cleaned each day, each week or each month. The external cleaning provider's supervisor attended weekly to review the logs and to identify and address any reasons or concerns for gaps.

For clinical areas, Optegra staff were responsible for cleaning the area they were assigned to that day. Each room that was used clinically had a cleaning record folder and these were complete and up to date. The cleaning plan and schedule was, where appropriate, individualised to the room and the equipment within it.

Good

Surgery

In theatre we observed staff adhering to social distancing measures and application of hand sanitiser and good hand washing technique. We looked at records to show that maintenance checks had been routinely carried out for theatre air flow systems and for legionella testing, including weekly flushing of water outlets.

Measures previously put in place to protect against COVID-19, such as social-distancing floor signs and screens had started to be relaxed with the easing of governmental restrictions. Patients and staff were still required to wear masks at the time of the inspection. The hospital had recently relaxed requirements and patients were not required to carry out Covid-19 testing (such as lateral flow tests) prior to arrival on site. On arrival at reception, patients with any adverse symptoms (such as high temperatures) were not admitted to the hospital and their appointment was rescheduled.

Staff followed infection control principles including the use of personal protective equipment (PPE). There were enough hand wash sinks and hand gels. Staff we saw were compliant with hand hygiene and 'bare below the elbow' guidance.

Staff used records to identify how well the service prevented infections. The service carried out hand hygiene audits at least every three months. Audit records between May 2021 and May 2022 showed six hand hygiene audits had been carried out. Five of the six audits showed 100% compliance, and the remaining audit showed 96% compliance.

All staff were required to complete an annual infection prevention and control course as part of mandatory training requirements. Infection control training compliance was 87% at the time of the inspection.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Environment hygiene audits were carried out every three months. Records between May 2021 and May 2022 showed three of the four audits achieved 100% compliance, and the remaining audit (February 2022) showed 94% compliance.

Staff also carried out routine decontamination and clinical waste audits. Audit results ranged between 93% and 99% between May 2021 and May 2022.

Staff worked effectively to prevent, identify and treat surgical site infections. The hospital reported surgical site infection (SSI) rates were consistently low between July 2021 and June 2022. The rate of eyes with endophthalmitis (inflammation due to infection) reported by the hospital as postoperative complication after intraocular lens surgery was 0.04%, which was better than the national benchmark of 0.1%. The rate of eyes with endophthalmitis reported by the hospital as postoperative complication after intravitreal injection was 0.01%, which was better than the national benchmark of 0.025%.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

All clinical areas were well maintained, free from clutter and provided a suitable environment for providing care and treatment to patients.

The design of the hospital environment followed national guidance. The clinical areas were located on the ground floor of the building and a ramp provided access to the entrance for patients who were living with mobility difficulties.

Patients attending for surgical appointments followed a defined route from the waiting area, through pre-admission checks through to the theatres and post-surgery recovery bays.

Good

Surgery

Staff carried out daily safety checks of specialist equipment. An emergency resuscitation trolley was located next to the theatres and a second trolley was located next to the outpatient suites. Staff undertook and recorded daily, weekly and monthly checks of the equipment on the trolley, including the automatic electronic defibrillator. Breakable tags were used to secure the contents of the trolley. The check logs were fully completed as required by the hospital's policy; we found no gaps or omissions in the check logs we looked at.

Cleaning kits were available in the event of any spillage, including for cytotoxic medicines. Any chemicals were stored in a locked cupboard identified for control of substances hazardous to health (COSHH) in a locked room.

Managers tracked the testing and maintenance of all hospital assets including clinical equipment. facilities management, using a health & safety balanced scorecard which included things such as electrical testing. Records showed the majority of equipment underwent routine maintenance and were within the service, calibration and electrical safety test due dates. The hospital's maintenance register showed only three items of equipment were overdue routine servicing. However, we saw evidence these had been risk assessed and had confirmed service dates booked.

The service had enough suitable equipment to help them to safely care for patients. The service held sufficient stocks of lenses to complete the number of procedures to be undertaken each day, including spare lenses for use in the event of a lens failure or damage.

The hospital used single-use, sterile instruments as appropriate. The single use instruments we saw were within their expiry dates. The hospital had arrangements for the sterilisation of reusable instruments which were contracted out and monitored through a service level agreement with an external provider.

Staff disposed of clinical waste safely. Clinical waste bins with orange waste bags were available in all clinical areas. Sharps bins were appropriately constructed, labelled and partially closed when not in use. Waste was stored in a secure compound external to the hospital until collected by an external contractor.

There was clear signage throughout the hospital, including emergency exit signs. Managers told us that the signage met guidance from the Royal National Institute of the Blind (RNIB). Fire extinguishers were located throughout the hospital; all extinguishers we checked had been tested. All staff (100%) had completed fire safety awareness training as part of the hospital's mandatory training programme. Five staff had also completed fire marshal training. Staff who were allocated on a daily basis to the fire marshal role were identified during the morning quality and safety huddle (QASH).

There was an uninterrupted power supply (UPS) in case of a power failure. This was primarily for the theatre areas and for equipment such as medicine fridges. The hospital had a business continuity plan which provided guidance for staff during emergencies.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration

Patients had an initial assessment to determine whether they were eligible to receive treatment at the hospital. The hospital's pre-assessment policy listed the eligibility criteria for patients to be admitted for treatment. The hospital admitted patients with an ASA score of 3 or below, which meant patients were generally healthy with some comorbidities. Patients who did not meet the admission criteria were sign posted to NHS acute services so they could receive further treatment, if required.

Good

Surgery

Patients with certain conditions required further assessment or treatment prior to undertaking eye surgery. If there were any identified concerns, patients were assessed and input from other health professionals (such as GP's) was sought to determine if the patient was suitable for admission.

Staff completed risk assessments for each patient on arrival. These included checking of the patient's medical history, any allergies, any medicines taken as well as observations of vital signs and an eye examination by an optometrist.

Patients were assessed by the ophthalmologist surgeon on the day of surgery to identify if there had been any changes to their medical condition since their initial consultation and a decision was made whether treatment could commence.

Staff used a recognised tool to assess patients, and reviewed this regularly, including after any incident. Staff used national early warning score systems (NEWS2) and carried out routine monitoring observations based on the patient's individual needs (such as weight, pulse and blood pressure checks) to ensure any changes to their medical condition could be promptly identified.

The registered manager told us they would contact the emergency services if a patient's health deteriorated during a procedure, so the patient could be transferred to the nearest acute hospital by ambulance. There had been no instances where a patient's health deteriorated during or after treatment and required urgent transfer to hospital during the past 12 months.

The registered manager reported there had been three instances in the past 12 months where patient's health deteriorated whilst on site prior to undergoing any treatment. The registered manager reported that in each case, the patients were stabilised and transferred to local NHS acute hospitals for further treatment. Following the inspection the provider checked and confirmed there had only been one instance where a patient's health deteriorated whilst on site prior to undergoing any treatment.

There was an Endophthalmitis standard operating procedure and a specific Endophthalmitis kit to treat patients should they develop a severe infection. Endophthalmitis is an infection of the tissues or fluids inside the eyeball. Managers informed us that this standard operating procedure is shared with all staff.

Patients undergoing eye surgery were treated using local anaesthetic only. Patients requiring treatment under general anaesthetic were referred to the acute NHS services for treatment.

Records showed 100% of staff had completed first aid training and 94.4% of staff had completed basic life support training as part of the mandatory training programme. Relevant clinical staff were required to undertake immediate life support (ILS) training and 98.1% of staff had completed this training. There was a hospital-wide resuscitation team and they were identified as part of daily staff huddles.

Staff completed the World Health Organisation (WHO) safety checklist for surgery that had been adapted and improved following learning from incidents in the organisation. We observed the use of the adapted ophthalmic surgical safety checklist and found this was completed appropriately. Staff carried out audits at least every three months to monitor adherence to the WHO guidelines and completion of the surgical checklist record. The audit results ranged between 99% and 100% between May 2021 and May 2022, demonstrating a high level of staff compliance.

Following surgery patients had access to a 24 hour helpline for any concerns. If the concern could not be resolved verbally or the following day, on call staff were available to review a patient in an emergency situation. Patients were provided with information about how to access support when they were discharged from the hospital.

Good

Surgery

The service had a number of lasers in place, such as laser eye surgery or yttrium aluminium garnet (YAG) laser treatment (used to clear any frosting from the back surface of a lens). We saw that the laser equipment was stored in designated areas and checks and risk assessments were carried out by trained staff before use, including use of appropriate personal protective equipment. The environment (temperature and humidity) in the designated laser rooms was monitored daily to ensure the machines operated within the manufacturer's parameters.

Each laser equipment had a set of local rules, policies and procedures and a designated list of staff that were trained to use the equipment. Records showed 100% of eligible staff had completed laser protection training. The outpatient's manager was the designated laser protection supervisor (LPS) and oversaw the laser protection policies and risk assessments. The LPS also carried out annual competency assessments for staff prior to then using the laser equipment. We looked at the competency records for four staff and these showed they underwent suitable training and assessment prior to using laser equipment.

The service also had an external laser protection advisor (LPA).

The laser protection advisor carried out an annual review of policies and risk assessments and provided guidance and support in relation to laser protection. The most recent review had been completed in October 2021 and the LPA reported the hospital as compliant with relevant laser protection standards.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing, theatre staff and support staff to keep patients safe. The hospital had low vacancy rates. The hospital manager reported there were 0.2 whole time equivalent nursing staff vacancies and two whole time equivalent healthcare technician vacancies at the time of the inspection and recruitment for the vacant post was on-going.

Managers accurately calculated and reviewed the number of nurses, theatre staff and healthcare technicians needed for each shift in accordance with national guidance. All procedures were planned in advance and staffing levels were based on the number of planned surgical procedures required.

The theatre team consisted of two scrub practitioners and two healthcare technicians that supported the ophthalmologist. There was an additional nurse coordinator for the post-procedure recovery and patient discharges. The day surgery manager oversaw the daily running of the clinic and supported patient access and flow.

The registered manager and hospital manager told us the hospital occasionally used bank and agency staff to cover for any leave or unplanned absence. Managers made sure all bank and agency staff had a full induction and understood the service.

The service had low sickness rates and staff turnover rates. The total staff sickness absence across the hospital was 5.8% (and 3.9% excluding Covid-19 sickness) between June 2021 and May 2022. The service also had low staff turnover rates. There had been no clinical leavers and three non-clinical leavers across the hospital during June 2021 and May 2022.

Medical staffing

Good

Surgery

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep patients safe. The hospital had 10 consultant ophthalmologists, of which nine were involved in surgery. All the consultants at the hospital worked under practising privileges.

The consultants were responsible for their individual patients during their hospital stay and were required to provide support to patients following their surgery. The hospital staff had a list of all consultants' contact details so they could be contacted if required. Where consultants were unavailable due to leave or sickness, an alternative consultant was identified to provide support to patients.

The service employed seven optometrists that reported to the hospital manager. The registered manager and the hospital manager told us they had sufficient medical staffing and there were no vacancies at the time of the inspection.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive and all staff could access them easily. Records were stored securely. Patient records were a combination of paper and electronic files.

We looked at the electronic and paper-based records for six patients. These were structured, legible, complete and up to date.

The paper records contained information such as the patients' contact details, consent forms, patient service contracts, clinical assessments and eye procedure records (such as safer surgery checklists, instrument traceability records and medicine charts). The electronic records included information such as patient's medical history, consultation notes, diagnostic scan images, treatment plans and follow-up notes.

The paper records contained information such as the patients' contact details, consent forms, patient service contracts, clinical assessments and laser eye procedure records (such as safer surgery checklists, instrument traceability records and medicine charts). The electronic records included information such as patient's medical history, previous medicines, consultation notes, diagnostic scan images, treatment plans and follow-up notes.

A health records audit was carried out every six months to check for accuracy and completeness of patient records. Audit results ranged between 90% and 98% between May 2021 and May 2022, indicating there was good compliance in records completion.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

There was a medicines management policy that provided guidance for staff on the handling, storage and administration of medicines. Staff also underwent competency-based training in relation to the administration of medicines, including eye drops.

Good

Surgery

Staff followed systems and processes to prescribe and administer medicines safely. Medicines used during eye surgery procedures and given to patients to take home were prescribed by the ophthalmologist.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Nursing staff that administered eye drop medicines underwent competency training and assessment prior to administering medicines. Patients were given information on 'to take home' medicines as part of their discharge consultation

Medicines, including controlled drugs, were securely stored. Staff carried out routine checks on controlled drugs and medicine stocks to ensure that medicines were reconciled correctly.

We looked at a sample of controlled drugs and routine medicine stocks and found the stock levels were correct.

We saw that medicines that required storage at temperatures between 2ºC and 8ºC were appropriately stored in medicine fridges. Fridge temperature logs showed that these were checked daily and the medicines we checked were stored at the correct temperatures.

Staff completed medicines records accurately and kept them up-to-date. We looked at the medicine administration records for six patients. Patients were given their medicines in a timely way, as prescribed, and records were completed appropriately. The records we looked at also showed patient allergy status had been documented.

The hospital had an arrangement with a local pharmacy provider for the supply and disposal of medicines. Staff told us they could contact the pharmacy service for advice and support if needed. The external pharmacy contractor also carried out an audit of medicines stocks at the hospital every three months.

Staff carried out routine audits to check compliance against medicines management policies. The medicines prescribing and administration audit results showed staff achieved 82% compliance in February 2022. This had improved during subsequent audits in April (99%) and May 2022 (100%), indicating good levels of staff compliance.

The medicines storage and disposal audit was carried out every six months. The audit results ranged between 97% and 99% during May 2021 and May 2022, indicating there was good staff compliance.

There was a policy and procedure for staff in the management and disposal of cytotoxic medicines. The policy clearly outlined the procedure for staff to follow in the event of spillage. Risks associated with the use of these medicines were identified within a risk assessment and actions were taken to protect the safety of patients and staff. For example, the surgeon took responsibility for prescribing the cytotoxic medicines and these were ordered as a pre-prepared solution specifically for each patient as required.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. The organisation used an electronic reporting system to report and record any incidents.

Good

Surgery

The service had policies and guidance in place for staff on how to identify, categorise by level of harm and report incidents.

Staff raised concerns and reported incidents and near misses in line with provider policy. All incidents, accidents and near misses were logged on an electronic incident reporting system. Incidents were reviewed and investigated by staff with the appropriate level of seniority, such as the senior managers.

New incidents were discussed at daily hospital-wide huddles at the start of each day. The senior managers reviewed all new incidents on a daily basis to identify any serious incidents that required immediate actions, such as escalation to the corporate provider or external reporting to organisations such as the Care Quality Commission or NHS service commissioners.

There had been one serious incident (moderate or above patient harm) reported in relation to the surgical services during the past 12 months. The hospital reported 187 incidents during the past 12 months and 77 (41.3%) of these related to the surgical services. The majority of incidents were graded as no or low risk incidents. The most frequent reasons for incidents were for clinical reasons, administrative errors and health and safety-related incidents.

The registered manager and the hospital manager told us if an incident was reported, it would be investigated by staff with the appropriate level of seniority. The registered manager told us information about incidents was shared with staff through monthly newsletters and discussed during routine staff meetings to improve practice and the service to patients. We saw evidence of this in the meeting minutes and newsletters we looked at.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We looked at a sample of two root cause analysis investigation reports and saw these were completed appropriately and showed remedial actions had been put in place to minimise the risk of reoccurrence. The investigation reports included information such as chronology of events, details of treatment undertaken, root cause leading to incident, duty of candour details, action plans and details of any good staff practice to aid learning.

There was a system in place to ensure safety alerts relating to patient safety, medicines and medical devices were cascaded to staff and responded to in a timely manner.

The registered manager and the hospital manager were aware of their responsibility to report notifiable incidents to the Care Quality Commission (CQC) and other external organisations.

Are Surgery effective?

Good

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Good

Surgery

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Care and treatment was delivered to patients in line with the provider's corporate national guidelines, Royal College of Ophthalmologists (RCOphth) standards and National Institute for Health and Care Excellence (NICE) guidelines in relation to refractive eye surgery.

Staff followed appropriate guidance such as NICE Interventional Procedures Guidance (IPG64) guidelines on photorefractive eye surgery and NICE guideline (NG77) for cataracts in adults. The national early warning system (NEWS) was used to assess and respond to any change in a patient's condition, in-line with NICE guidance CG50. The theatre teams also used the 'five steps to safer surgery' checklist, based on World Health Organisation guidance.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. At staff huddles, staff routinely referred to the psychological and emotional needs of patients. Patients' needs were assessed individually to ensure appropriate care and treatment was provided.

All patients undergoing procedures had their needs assessed and their care planned prior to any treatment. All treatments offered were based on the clinical need of the patient and were delivered in line with evidence based guidance and professional standards. Where it was assessed that patients were unsuitable for a particular treatment or were more suitable for a treatment provided outside of the services at the clinic, patients were duly advised and signposted accordingly.

Changes to clinical practice, national guidance and policies were reviewed and developed centrally by the corporate provider and cascaded to the hospital and shared with staff. Policies based on best practice and clinical guidelines were developed nationally and cascaded to the hospitals for implementation. We saw evidence that changes in practice and guidance updates were routinely discussed as part of routine clinical governance and medical advisory committee meetings.

Staff told us policies and procedures reflected current guidelines and were easily accessible electronically. We reviewed a sample of policies and guidelines and found that all were within their review dates and reflected national guidelines.

Nutrition and hydration

The service provided day case eye surgery procedures and hydration and nutrition assessments were not routinely carried out due to the nature of the treatments provided.

There were no prerequisite nutrition and hydration requirements for patients in relation to refractive eye procedures carried out at the clinic.

Patients were only present on site for a short period of time, they were offered refreshments, not food. However, if for any reason they were on site for a longer period, food was ordered for them.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way.

Staff assessed patients' pain and gave pain relief in line with individual needs and best practice. Staff prescribed, administered and recorded pain relief accurately. Patients received local anaesthetic eye drops before and after surgery to minimise pain symptoms.

Patients were given verbal and written information to take home which provided information on how to manage pain symptoms following discharge from the hospital.

The patients we spoke with told us they were kept comfortable throughout their eye procedure and their pain symptoms were effectively managed by staff.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant national clinical audits. Outcomes for patients were positive, consistent and met expectations, such as national standards.

The hospital had an eye sciences division, which managed the collection and reporting of clinical data. This data covered clinical complications, visual and refractive outcomes for laser, lens replacement and cataract patients.

The hospital reported outcomes data relating to NHS cataract procedures to the National Ophthalmic Database Audit (NODA). The case complexity adjusted posterior capsular rupture rate **(**PCR) as reported in the latest NODA audit for cataract surgery (for the period between April 2021 and March 2021) was less than 0.4% and better than the NODA overall benchmark of less than 0.7%. The visual acuity (VA) loss related to surgery was 0.1% at this hospital and better than the NODA overall benchmark of less than 0.4%.

The hospital submitted data to the Private Healthcare Information Network (PHIN). This is an independent, government-mandated source of information about private healthcare which supports patients to make better-informed choices of care provider. PHIN data did not identify any concerns in relation to his service.

The hospital also collated data for individual ophthalmologist surgeon's outcomes. This data included data on number of treatments, the number of complications and patient outcomes measured against benchmark standards.

We looked at the outcomes data for six consultant ophthalmologist surgeons for the period between January 2021 and December 2021 and data for one surgeon between January 2022 and March 2022. These showed the surgeons performed similar to or better than provider and national standard benchmarks for complication rates, number of eyes achieving 6/12 and 6/6 or better and number of eyes within plus or minus 1.00 and 0.50 of predicted post-operative refraction (PPOR) error rates.

6/12 vision means that a patient can see at six metres, what a 'normal' person can see at 12 metres from the vision chart. 12/12 vision means that a patient can see at six metres, what a 'normal' person can also see at the same distance on the vision chart.

Managers used information from the audits to improve care and treatment. The ophthalmologists were presented with their outcome data, as part of the annual appraisal process. Meeting minutes showed outcomes data was also reviewed as part of routine hospital and corporate provider medical advisory committee meetings to monitor performance and identify improvements.

Competent staff

Good

Surgery

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Managers gave all new staff a full induction tailored to their role before they started work. Newly appointed staff were 'buddied up' with an experienced member of staff for support. The induction included all staff, spending time in another Optegra hospital in order to gain an understanding of the patient experience and journey through the hospital.

Staff underwent a probationary period with regular meetings to support staff and review performance. They completed the necessary competencies and assessments prior to undertaking work unsupervised. Agency staff also had inductions before starting work.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff told us they received routine supervisions and an annual appraisal. Records showed appraisal compliance for all hospital staff was 87% at the time of the inspection. This showed most staff had completed appraisal. Appraisals compliance was monitored as part of routine monthly staff training meetings and clinical governance meetings held every three months. Following the inspection, the provider confirmed that all staff had now received an appraisal.

Consultants working under practicing privileges were required to submit evidence of their clinical appraisal annually from their substantive employer (such as the NHS trusts) and this was reviewed as part of the practicing privileges processes. Where consultants did not have substantive employment within the NHS, the provider arranged for their appraisal to be completed by a designated responsible officer.

Staff were experienced and had the right skills and knowledge to meet the needs of patients.

Staff received competency-based training and assessments specific to their role covering a range of areas, such as clinical competencies, the use of specialist equipment, vital signs, administering medicines and for use of laser equipment and role-specific theatre staff competencies. Competencies were reviewed and updated on an annual basis and compliance was monitored using an electronic tracker which flagged when updates were due. Records showed the overall competencies completion rate across the hospital was 95% at the time of the inspection. The hospital reported there were a number of new starters that were in the process of but had not yet completed all their competencies.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff we spoke with were positive about on-the-job learning and development opportunities and told us they were supported well by their line managers.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. There was effective daily communication between multidisciplinary teams within the surgical areas. Staff handover meetings took place during shift changes and 'safety huddles' were carried out on a daily basis to ensure all staff had up-to-date information about risks and concerns.

Good

Surgery

There was effective daily communication between multidisciplinary teams within the hospital. Nursing and healthcare staff told us they had a good relationship with the optometrists and ophthalmologists. At the beginning of each surgery day, the team completed a team brief (huddle) to discuss patient safety and individual staff roles and responsibilities. There was regular communication between the day surgery manager, outpatient's manager and the bookings teams so patient care could be coordinated and delivered effectively.

Staff worked across health care disciplines and with other agencies when required to care for patients. There were contractual arrangements in place with a number of external organisations to support processes such as equipment maintenance, sterilisation of surgical instruments, pharmacy services and clinical waste disposal.

Staff at the clinic also liaised with some patients' general practitioners (GP's) to confirm their health status where patient risks were identified as part of the initial per-operative assessments, including any risks around patient capacity or mental health.

Seven-day services

The hospital did not provide seven-day services.

The hospital did not operate over seven days. The hospital routinely operated from 7am to 7pm during weekdays with occasional theatre lists on Saturdays for a limited number of hours if additional capacity was required.

Patients were provided with an emergency contact number so they could contact staff at any time in case of a medical emergency or complication following discharge.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The hospital offered limited health promotion advice due to the specific and specialist nature of the treatments provided.

Staff told us they offered verbal advice and information leaflets relating to the eye procedures and discussed lifestyle choices relating to their vision needs as part of the initial consultation process. Information was also available on the provider's website.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Records showed 94% of staff had completed this training across the hospital.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available.

Good

Surgery

Patients underwent initial consultation with an optometrist or ophthalmologist. The risks and benefits were discussed with the patient to enable them to make an informed decision about their procedure and written consent was obtained. Consent was also obtained a second time on the day of surgery before the patient underwent laser eye surgery.

Staff clearly recorded consent in the patients' records. We looked at six patient records. These showed that written consent had been obtained from patients and that planned care was delivered with their agreement. Consent forms showed the risks and benefits were discussed with the patient prior to carrying out eye surgery procedures.

There was a minimum of seven days 'cooling off' period from the initial signed consent to the day of surgery, in line with the Royal College of Ophthalmologists guidance (updated December 2021).

The hospital carried out consent audits at least every two months. Records showed audit compliance ranged between 95% and 100% between May 2021 and May 2022, indicating high levels of staff compliance.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. If a patient lacked the capacity to make their own decisions, staff told us they sought consent from an appropriate person that could legally make decisions on the patient's behalf. The registered manager and the hospital manager told us consultants undertook best interest decisions meeting with input from the patient's relatives and other healthcare professionals (such as the patient's GP). We saw evidence of this in one patient record we looked at.

Private fee-paying patients were provided with information about fees and charges as part of the initial consultation process and these were clearly explained to them prior to undergoing any treatment.

The registered manager and the hospital manager told us if they identified patients with certain mental health conditions (such as depression, anxiety or risk of low mood) they sought input from a patient's GP before a decision could be made as to whether eye surgery was suitable for the patient or whether alternative treatments may be more beneficial for the patient.

Are Surgery caring?

Good

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff followed policy to keep patient care and treatment confidential. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed good interactions between all staff and patients. Patients were welcomed into the building and spoken to in a way that put them at ease.

Good

Surgery

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

We spoke with two patients that had undergone surgical treatment. Patients said staff treated them well and with kindness. The comments received included; 'staff are friendly' and 'everyone has been brilliant; I would recommend this service to everybody'.

Staff sought feedback from patients about the quality of the service provided through feedback surveys. The survey feedback was collated on monthly basis. The friends and family survey results for August 2021 to May 2022 showed almost 100% of patients rated the service as very good or good. The patient feedback received was very positive in relation to the care they received and the number of responses received was high, with up to 1300 responses per month during this period.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. We observed staff putting patients at their ease particularly when they expressed feeling anxious.

There were chaperone posters displayed for patients who needed support.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff we spoke with were clear about how the treatments resulted in positive outcomes for patients both physically and emotionally.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Patients we spoke with told us they were kept informed about their treatment and staff were clear at explaining their treatment to them in a way they could understand. The comments received included; 'was given all information needed for procedure and 'the risks and benefits [of the treatment] were clearly explained'.

Patients also spoke positively about the verbal information and support they received from staff before, during and after their procedure.

Staff assessed patients preferences and allowed patient's relatives or carers to accompany them if it was safe to do so.

Good

Surgery

Are Surgery responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The service was commissioned by the NHS to provide cataract surgery and age-related macular degeneration (AMD) treatments for the local adult population on a day case basis. Managers took part in clinical commissioner group (CCG) contracts meetings every three months to review performance and risks.

The hospital also provided a range of procedures for private fee paying patients, such as refractive laser eye surgery, lens exchange surgery and intraocular lens implant procedures. All treatments were provided for adult patients only. The registered manager and the hospital manager reported that 80% of surgical procedures were for NHS patients.

The provider's centralised bookings teams managed the patient referrals on an electronic patient administration system. Patients were required to attend for a pre-assessment clinic to ensure they were suitable for surgery. A date for surgery was given to the patient prior to leaving.

Facilities and premises were appropriate for the services being delivered. The hospital had two theatres and a 12-bedded day case area, which was split into six day-case beds per theatre. Each cubicle was segregated to maintain privacy and dignity. The hospital did not provide inpatient accommodation.

The service had sufficient capacity to meet the needs of the patients they saw. All patients were booked in advance so services and appropriate staffing could be planned prior to patients attending their appointment.

Meeting people's individual needs

The service was inclusive and proactively took account of patients' individual needs and preferences. Staff gave careful consideration to make reasonable adjustments to help patients access services. They coordinated care with other services and organisations.

The service had a standard operating procedure to ensure they met the national accessibility requirements. Any requirements a patient required was documented on both the patient administration and clinical administration system and in the paper records.

Managers made sure patients could get help from interpreters when needed. Hearing loops were available for patients with a hearing impairment. Sign language interpreters could be booked if needed for support.

The service had information leaflets available in languages spoken by the patients and local community. Leaflets, about the procedures, were available in languages other than English and in larger fonts.

Good

Surgery

Each patient was individually assessed at the pre assessment clinic. Any patient identified with reduced mobility or communication concerns had their needs assessed, recorded on the patient record and a plan made to address any issues identified as necessary.

The clinical areas were accessible and based on the ground floor of the building. Toilets were also accessible for patients with mobility needs.

There was an equality policy that included the management of patients with a disability. This included an individualised risk assessment approach to assess and plan care in the best interests of the patient. All staff (100%) had completed a module for equality, diversity and human rights as part of their mandatory training.

There was a proactive approach to understanding the needs and preferences of different groups of people and to delivering care in a way that met those needs, which was accessible and promoted equality. This included people with protected characteristics under the Equality Act, and people who were in vulnerable circumstances or who had complex needs.

Records showed 94% of staff had completed dementia awareness training. For patients living with a learning disability or autistic spectrum disorder, they were offered additional visits, with those close to them, to help with preparations or scheduling their procedure to be carried out at the start or end of the theatre list.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Patients accessed the services through a number of routes, such as referral to the central booking team via their GP, optician or NHS Trust, as well as through self-referral. When a patient made an initial enquiry about the services offered at the hospital, an initial consultation appointment was made and they were given verbal and written information about the types of treatments offered.

Patients were then reviewed by an optometrist or ophthalmologist before treatment.

They reviewed the patient's suitability for surgery and the previously completed pre- operative assessment. As part of this consultation, a review of the patient's medical history was carried out to determine whether they were suitable to undergo treatment at the hospital. The ophthalmologist saw each patient on the day of surgery to check if there had been any changes to their health, personal circumstances and to confirm patient consent for treatment.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The service collated monthly performance information on referral to initial consultation and referral to treatment for NHS cataract and age-related macular degeneration (AMD) patients.

Records showed the average monthly referral to treatment wait times for NHS cataract patients had been over 13 weeks between June 2021 and October 2021. However, this had consistently improved each month to just over six weeks between February 2022 and April 2022. The hospital reported average wait times of 4.8 weeks during the latest month (May 2022).

Good

Surgery

The average monthly referral to treatment wait times for NHS AMD patients ranged between 1.2 and two weeks between June 2021 and May 2022.

The hospital manager told us they did not have a performance target for referral to treatment waiting time for privately funded patients (such as those requiring laser eye surgery) because appointment dates were based on a patient's own preferences. The registered manager confirmed most privately funded patients underwent surgery within approximately four weeks of their initial consultation.

The patients we spoke with and patient records we looked at also showed patients did not experience long waits from referral to treatment.

Patients were given staggered appointment times during the day so they did not experience long waits on the day of surgery. The total time each patient spent in the theatre was approximately 20 minutes. We saw there was sufficient time for theatre staff to carry out their duties (such as complete checks and records and preparing for next patient) in between patients.

Managers and staff worked to make sure patients did not stay longer than they needed to. The patients stayed in the recovery area for up to 40 minutes following the procedure. Staff planned patients' discharge individually. This included those who were in vulnerable circumstances or who had complex needs. All patients had a discharge consultation with a registered nurse after their procedure to ensure they were able to administer any eye drops. Patients were given guidance and information both verbally and in writing as part of the discharge consultation.

Staff made sure patients were safe to leave and travel home. Discharge letters were routinely sent to a patient's GP unless a patient had specified they did not want these to be sent.

Patients that were discharged from the hospital were given an emergency contact number so they could speak with a member of staff as part of the aftercare process.

Patients were given a post-operative follow up appointment with the consultant at routine intervals as required depending on the type of procedure they had. For example, patients that had undergone laser eye surgery received a follow up appointment within 24 hours of discharge to discuss any concerns the patient may have.

The hospital reported instances where procedures had been cancelled. The overall average percentage of patient surgery cancellations was 3.3% between May 2021 and April 2022. The hospital reported cancellations were mainly due to clinical reasons, most commonly due to patient being unwell on the day of surgery (such as blood pressure too high, patient had an infection or had been in acute hospital recently). All patients were rebooked for treatment within 28 days of their cancellation.

The service monitored patients who failed to attend. The proportion of patients who did not attend (DNA) appointments was 5.5% across the hospital between May 2021 and April 2022. The DNA rate for surgical patients was 3.3% during this period. Managers ensured that patients who did not attend appointments were contacted. Staff contacted patients who had failed to attend to re-book or refer back to their GP (for NHS patients).

Learning from complaints and concerns

Good

Surgery

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. Managers shared feedback from complaints with staff and learning was used to improve the service.

All complaints were investigated in line with the company complaints policy and discussed within hospital and department team meetings. The clinical governance committee was responsible for reviewing themes and trends from any complaints.

The complaints policy stated that formal complaints would be acknowledged within two working days and responded to within 20 working days. Where patients were not satisfied with the response to their complaint, they were given information on how to escalate their concerns within the organisation (to the head of clinical governance and risk) who were required to send a response within 20 working days.

If patients were still not satisfied, they were given information on how to escalate their complaint to external organisations such as the Parliamentary and Health Service Ombudsman (for NHS patients) and the Independent Sector Complaints Adjudication Service (ISCAS) for private funded patients.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

The hospital had received 12 complaints during the past 12 months, of which six complaints related to surgery and surgical outcomes. The most frequent reason for complaints related to patient experience and care and treatment. Records showed the majority of complaints were responded to in a timely manner and within the hospital's specified response timelines.

We also looked at the records for two complaints received during October and November 2021 and the responses were appropriate and completed in a timely manner.

Are Surgery well-led?

Good

Our rating of well-led improved. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

Good

Surgery

The overall responsibility for the hospital was with the registered manager, who was also the regional head of clinical services. The registered manager also had responsibility for another of the provider's hospitals.

The day to day running of the hospital was managed by the hospital manager, who reported to the regional director. The hospital manager was supported by the surgery manager, outpatients department manager, the administrative team manager and the optometrist team manager. The day surgery manager was responsible for managing the day case and theatre areas.

The managers had the relevant skills and abilities to manage the surgical services effectively. They understood the risks to the services and had clear oversight on patient safety, governance and performance issues through daily involvement and quality monitoring.

A daily safety and quality huddle (QASH) took place at the start of each day. This was attended by the senior management team and heads of department. There were also daily safety huddles and team briefings in the day case and theatre areas so that staff received all relevant information.

The nursing, support and medical staff we spoke with told us they understood the reporting structures clearly and described their line managers as approachable, visible and who provided good support.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. Leaders and staff understood and knew how to apply them and monitor progress.

The provider's mission statement was 'to be the most trusted eye care provider'.

This was underpinned by a set of four values; 'we are safe', 'we are focussed', 'we move fast' and 'we are brave'.

The hospital's clinical 'game' plan 2022 outlined the hospital's strategy and objectives for the current year. This included specific clinical and workforce objectives, such as improving incidents, medicines management, infection control and resuscitation processes and development of staff training plans and leadership development.

Progress against key objectives was monitored and reported as part of routine clinical governance meetings and medical advisory committee meetings.

The mission statement, values and strategic objectives were clearly displayed on notice boards across the day case and theatre areas. They had been cascaded to staff across the services and the staff we spoke with had a good understanding of these. Objectives were also incorporated into individual staff appraisals.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

All the staff we spoke with were highly motivated and positive about their work. They told us there was a friendly and open culture and that they received good support from the their colleagues and managers.

There was a whistle blowing policy and the hospital had a freedom to speak up guardian in place. Staff were aware of the process to follow if they wished to raise any concerns. There had been no reported whistle blower concerns or concerns raised with the freedom to speak up during the past 12 months. There were elements of strong leadership which supported a constructive culture among staff, this had a positive impact on sickness levels.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were clear governance structures in place that provided assurance of oversight and performance against safety measures.

The hospital participated in medical advisory committee (MAC) meetings every three months led by the MAC chair. The MAC meetings were attended by the site management team and surgical specialty lead consultants. Recent meeting minutes showed the MAC undertook reviews of new and updated guidance, consultants' performance, practicing privileges reviews as well as a review of governance and key risks.

The hospital held clinical governance meetings every three months and were attended by the senior managers and departmental leads. Meeting minutes from October 2021 to April 2022 showed discussions took place around performance and quality, governance, incidents, complaints and audit performance.

There were a number of groups and committees in place that held meetings either monthly or every three months and reported to the senior management team. This included the medicines management committee, resuscitation meeting, infection prevention and control meeting, age-related macular degeneration (AMD) team meetings, staff training meetings and clinical staff meetings.

Each meeting had standardised agenda and action logs to monitor improvements to the services.

We looked at a range of meeting minutes from September 2021 to May 2022 these showed discussions around incidents, complaints, audits, performance, risks and changes to guidance were routinely discussed as part of these meetings. Meeting minutes showed action plans were in place and these were followed up at subsequent meetings.

There was regular communication and oversight from the corporate provider. The senior management team and departmental leads routinely reported governance, performance and risks to the corporate provider. The senior managers and departmental managers participated in regular peer meetings to share learning and benchmarking with the provider's other hospitals across the region and nationally.

The site management team carried out daily and weekly informal meetings to review key risks and performance. The senior managers also held daily and weekly informal meetings to discuss day to day issues. There were daily huddles held in the day case and theatre areas and a hospital-wide quality and safety huddle (QASH) was held daily to manage patient risks and cascade governance information to staff.

Practising privileges were routinely reviewed and authorised by the regional head of clinical services, regional director and the MAC chair and were also reviewed at the medical advisory committee.

The hospital reported there were no outstanding queries relating to practising privileges. We looked at the records for two consultants who worked across both the surgical and outpatient services. These contained up to date appraisal records, General Medical Council (GMC) revalidation, indemnity certificates and Disclosure and Barring Service (DBS) checks.

We also spoke with two surgical consultants, who told us practising privileges were reviewed annually and they were required to submit updated appraisals, GMC registration information and indemnity insurance information to the hospital on an annual basis. The hospital manager told us any individuals working under practising privileges received reminders to submit required documentation annually and individuals who did not submit the required information within required timelines would have their practising privileges removed or suspended.

The service had a centralised human resources team that monitored compliance with the Fit and Proper Person Requirement (FPPR) of the Health and Social Care Act. This regulation ensures that leaders have the essential skills and competencies to manage an organisation. We looked at the recruitment records for the hospital manager and the registered manager (also the regional head of clinical services and found appropriate checks had been carried out in line FPPR requirements.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The key risks relating to the surgical services were incorporated into the hospital wide risk register. The risk register showed that key risks were identified and control measures were put in place to mitigate risks. Risks had a review date and an accountable staff member responsible for managing that risk.

Staff were aware of how to record and escalate key risks on the risk register. A risk scoring system was used to identify and escalate key risks to the senior management team and to the corporate provider.

Key risks and risk register entries were reviewed at routine clinical governance, medical advisory committee and senior management team meetings.

Routine staff meetings took place to discuss day-to-day issues and to share information on performance, complaints, incidents and audit results.

We saw that routine audit and monitoring of key processes took place to monitor performance against patient safety standards and organisational objectives. There was a structured programme of audit covering key processes such as infection control, patient records, surgical safety and medicines management. Records showed staff achieved good levels of compliance across most audits over the past 12 months.

Information relating to performance against key quality, safety and performance objectives was monitored and cascaded to staff through routine team meetings, safety huddles, performance dashboards and newsletters. Audit findings were also reviewed at routine departmental and hospital-wide meetings and monitored centrally by the corporate provider to look for improvements to the service.

Good

Surgery

The provider had developed a 'caring, responsive, effective, well-led and safe' (CREWS) accreditation programme which involved a visit by the corporate provider governance team to assess compliance against the Care Quality Commission's standards every three months. The most recent CREWS accreditation visit took place during May 22 and the hospital achieved a score of 87%. The registered manager and the hospital manager reported this was among the highest scores achieved across the provider's hospital locations.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Performance information was collected and analysed by the surgical services and was used to develop and support the delivery of services. Staff used electronic systems for the real-time planning and monitoring of patient flow, theatre utilisation and cancellations. The surgical services had performance dashboards in place that were updated monthly and provided a detailed overview of patient safety, performance and staffing indicators.

Staff completed General Data Protection Regulation (GDPR) training as part of their mandatory training. Training compliance across the hospital was 98.1%, indicating most staff had completed this training.

We did not identify any concerns in relation to the security of patient records during the inspection. Paper-based patient notes and staff records were kept securely. Records such as such as staff recruitment records, audit records and staff rotas were held electronically.

The corporate group operations director was the data protection lead for the service. The hospital reported there had been no data breaches that were reportable to the Information Commissioner's Office (ICO) in the past 12 months.

Computers were available across the day case and theatre areas and staff access was password protected. Staff we spoke with did not identify any concerns relating to accessing IT systems or any connectivity issues.

There were a number of notice boards across the hospital that displayed information such as audit and survey results, safety bulletins, meeting minutes, quality and performance dashboards, patient safety and infection control information.

Staff could access policies, procedures and clinical guidelines through the provider's electronic systems. Staff told us they could access patient information and up to date national best practice guidelines and prescribing formularies when needed.

Engagement

Leaders and staff actively and openly engaged with patients, staff and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Staff told us they received good support and regular communication from the local management team and the wider organisation. Staff at the hospital routinely participated in hospital-level and team meetings and participated in regular meetings with peers across the provider's other locations. Staff engagement also took place through emails, daily huddles, newsletters and through other general information and correspondence that was displayed on notice boards.

Good

Surgery

The service carried out an annual staff survey to gain feedback from staff about their experiences. The survey consisted of six indicators; process, engagement, structure, strategy, team environment and leadership.

The most recent hospital-wide staff survey (2021/2022) showed staff responses were positive around the six indicators, indicating staff were very positive about the support they received from the local management team.

Staff working at the hospital could access additional support, such as counselling or emotional support through the corporate provider's occupational health team if needed.

Staff told us they routinely engaged with patients to seek feedback about the quality of the service provided. This was done through informal daily engagement and through feedback surveys. The findings from the friend and family survey showed patient feedback was very positive in relation to the care they received.

Staff reviewed patient survey feedback to look for improvements to the service. The service had recently moved staff parking offsite to increase patient car parking facilities following feedback from patients during recent surveys.

The registered manager and the hospital manager told us they routinely engaged with the public to promote services through the provider's website, through local events and through the use of social media. The hospital had also implemented a patient focus group to enable patient engagement.

Staff routinely engaged with other healthcare professional (such as GP's) involved in their care and treatment. Staff also held routine engagement meetings with local commissioners regarding performance around care and treatment provided for NHS patients.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

The culture across the services was based on innovation, learning and quality improvement. We found significant improvements had been made since our last inspection in July 2017. We also identified improvements in performance such as for referral and treatment waiting times for NHS cataract patients.

The hospital was committed to providing a service that was continually evolving and improving as a result of learning or research.

The hospital's clinicians and the eye services division were involved in a number of clinical research projects. This included clinical studies for use of novel intravitreal (eye injection) medicines for AMD patients and a study to review clinical and patient reported outcomes of post laser vision correction patients implanted with an extended depth of focus.

The hospital was involved in a study to report on the clinical outcomes of elective intraocular lens surgery in patients with high ametropia (blurred vision). The hospital also ran a project to look at patient satisfaction with a nurse led injector service delivery.

Good

Outpatients

Safe	Good
Effective	Inspected but not rated
Caring	Good
Responsive	Good
Well-led	Good

Are Outpatients safe?

Good

Our rating of safe stayed the same. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

All staff including medical, nursing, healthcare technician and administration staff received and kept up to date with their mandatory training. Training was delivered through a combination of eLearning and face to face training. The average compliance rate for mandatory training for all hospital staff was 98.3%.

Mandatory training modules included, but were not limited to manual handling, basic life support and infection prevention and control. The training was comprehensive and met the needs of patients and staff.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

The service had an up to date safeguarding policy that was available for all staff to review. The policy set out the staff responsibilities and what to do if there was a safeguarding concern.

Staff received training specific for their role on how to recognise and report abuse. All eligible staff (100%) had completed level one and level two safeguarding adults training within the previous 12 months. For level one and level two safeguarding children training, all but two staff members (96.3%) eligible for the training had completed it within the previous two months.

All staff (100%) had completed PREVENT training.

Prevent training aims to ensure the safeguarding of children, adults and communities from any threat of terrorism.

Six staff including the hospital's registered manager and day case theatre manager were eligible for and had completed level three safeguarding adults and children and 'Prevent Duty' training. They worked with external organisations to obtain advice or to escalate safeguarding concerns if needed.

There was a nominated safeguarding lead to provide support and advice to staff to ensure compliance with the organisation safeguarding policy.

Staff we asked gave a range of examples of how to identify and protect patients at risk of significant harm, abuse, harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff described who they would report their concerns to within the hospital and, where to get additional support and advice if a level three trained staff member was not on site at the time.

Staff followed safe procedures for children attending the hospital. The hospital did not treat any patients under the age of 18, but staff recognised the need for such procedures as children may accompany a parent or relative for their appointment.

Cleanliness, infection control and hygiene

The hospital controlled infection risk well. It used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

The provider had an infection prevention and control precautions policy that had recently been reviewed and was stored on the document library for all staff to review. We saw that the policy contained the essential principles of infection prevention and control and the management of serious ophthalmic infections.

There was a nominated infection prevention and control lead clinician and link nurse for the service. Their role included providing advice and support to staff to ensure compliance with organisational policy.

Clinical areas were clean and had suitable furnishings which appeared clean and well-maintained.

All areas of the hospital were visibly clean and had suitable cove-skirting flooring types and furnishings which appeared clean and well-maintained.

The hospital sub-contracted the cleaning of all areas to an external cleaning provider under a service level agreement arrangement. The housekeeper had a schedule of works log which set out the specific areas to be cleaned each day. The external cleaning provider's supervisor attended monthly to review the logs and to identify and address any gaps or concerns.

For clinical areas, Optegra staff were responsible for cleaning the area they were assigned to that day. Each room that was used clinically had a cleaning record folder. The cleaning plan and schedule was, where appropriate, individualised to the room and the equipment within it.

Consumable stock was kept in a storeroom. Stock was stacked on racks off the floor. Items we checked all had visible expiry dates.

Spill kits were used in the event of blood or bodily fluid spills. These kits were pre-prepared ready for staff to use.

Measures previously put in place to protect against COVID-19, such as social-distancing floor signs and screens were starting to be relaxed with the easing of governmental restrictions. However, some precautions remained in place. Patients and staff were still required to wear masks at the time of the inspection. On arrival at reception patients were asked to confirm they had undertaken a lateral flow test with a negative result and were provided with a fresh face mask. Surgical patients were required to complete and sign a COVID-19 self-assessment declaration form; completed forms were held in the patient's paper record.

Staff followed infection control principles including the use of personal protective equipment (PPE). Each clinical room included electronic non-touch activated sinks.

All staff were required to complete an annual infection prevention and control course as part of mandatory training requirements. At the time of the inspection 87% had completed the course.

Staff cleaned equipment after patient contact, and labelled equipment to show when it was last cleaned. Environment hygiene audits were carried out quarterly. Between May 2021 and May 2022, three of the four audits showed 100% compliance, and the remaining audit showed 94% compliance.

Audits were completed in relation to hand hygiene. A total of five audits had been completed between May 2021 and April 2022. Average compliance across the year was 99.2%. The compliance rate was 95%.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The hospital was located on the ground floor of a modern multi-use building. The hospital had a dedicated entrance that was accessed direct from the car park. A ramp provided access to the entrance for patients who were living with mobility difficulties.

Patients attending for surgical appointments followed a defined route from the waiting area, through pre-admission checks through to the theatres and post-surgery recovery ward.

Staff carried out daily safety checks of specialist equipment. An emergency resuscitation trolley was located next to the outpatient's suites. Staff undertook and recorded daily, weekly and monthly checks of the equipment on the trolley, including the automatic electronic defibrillator. Breakable tags were used to secure the contents of the trolley. The check logs were fully completed as required by the hospital's policy; we found no gaps in the log.

Cleaning kits were available in the event of any spillage. Any chemicals were stored in a locked cupboard identified for control of substances hazardous to health (COSHH) in a locked room.

Managers tracked the testing and maintenance of all hospital assets including clinical equipment; including electrical testing. The organisation held records of all equipment to show that maintenance checks had been routinely carried out. At the time of the inspection there were three pieces of equipment that were overdue maintenance; however, clear and valid reasons were recorded for the delay.

Staff disposed of clinical waste safely. Clinical waste bins with orange waste bags were available in all clinical areas. Sharps bins were appropriately constructed, labelled and partially closed when not in use. Waste was stored in a secure compound external to the hospital until collected by an external contractor.

The provider audited the environmental hygiene as part of its audit program. From May 2021 to April 2022, three audits had taken place with an average compliance rate of 98%.

There was clear signage throughout the hospital, including emergency exit signs. Managers told us that the signage met guidance from the Royal National Institute of the Blind (RNIB).

Fire extinguishers were located throughout the hospital; all extinguishers we checked had been tested. All staff had completed fire safety awareness training within the previous 12 months as part of the hospital's mandatory training programme. Six staff had completed fire marshal training. Staff who were allocated on a daily basis to the fire marshal role were identified during the morning quality and safety huddle (QASH).

There was an uninterrupted power supply (UPS) in case of a power failure. This was primarily for the theatre areas and for equipment such as medicine fridges. The hospital had a business continuity plan which provided guidance for staff during emergencies.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Clinical staff routinely accessed their electronic system to review any concerns highlighted about referred patients. This included imaging and patient information.

In the event of a patient collapsing at the location, staff called 999 for an emergency ambulance to transport to the local NHS hospital trust. There were sufficient skilled staff to support patients in the event of an emergency. The service training matrix showed 94.4% of eligible staff had completed basic life support skills and 98.1% of eligible staff had completed intermediate life support skills.

The training matrix provided by the service showed 100% of staff had completed first aid training.

Staff completed e-Learning as part of statutory and mandatory training.

At pre-assessment patients confirmed they were eligible for surgery against Optegra policy criteria. For example, being able to lie flat for surgery. If they did not meet the criteria they were signposted back to the NHS.

Patients identified as needing more complex surgery were referred to other locations with specialist surgeons.

On discharge copies of the discharge letter were sent to the patient's GP and the community optometrist as well as sharing with the patient.

Following surgery patients had access to a 24 hour helpline for any concerns. If the concern could not be resolved verbally or the following day, on call staff were available to review a patient in an emergency situation. Patients were provided with information about how to access support when they were discharged from the hospital.

The organisation had developed a post-operative review service with accredited community optometrists. Four weeks following surgery patients attended an appointment in the community or at the service to review the results of the treatment.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The service had enough nursing and support staff to keep patients safe. The department used one health care technician per clinic to support and provide care to patients. The staffing numbers were based upon the number of patients being seen on that day. Following our inspection, the service told us the healthcare technician was overseen by the department manager.

Medical staffing worked between outpatients and surgery. Medical staff reviewed each of their patients in preoperative consultation clinics prior to surgery. There was a total of 10 consultants that worked across the service to see and treat patients.

Data supplied by the provider showed the staffing numbers to be stable. From June 2021 to May 2022, there had been only three whole time equivalent leavers. There were currently no vacancies. Staff we spoke with confirmed that, so few staff left the service.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift. Staff worked flexibly between outpatients and surgery to ensure correct staffing levels were maintained.

The manager could adjust staffing levels daily according to the needs of patients. Data supplied by the provider showed a fill rate of staff to cover clinic shifts as 100%.

The total sickness absence rate over a 12 month rolling period from June 2021 to May 2022 was 5.8% (excluding Covid-19=3.9%).

Shortfalls in staffing were supplemented by regular agency staff who had been fully inducted in the services processes and competencies. These were regularly block booked for continuity of care.

There was a recruitment policy in place to support staff in all procedures in relation to recruitment and selection of employees. This included reference to the procedures to comply with equal opportunities and the dignity and diversity policies.

Managers told us that if necessary, the number of patients booked, on a particular day would be reduced and re booked in line with staffing numbers.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily.

We reviewed clinic proformas used to collect patient information. We found the proformas contained necessary information relating to allergies, consent, treatment site, medications, and patient identifiers.

Records were stored securely. Patient records were a combination of paper and electronic. Paper packs were stored in case of a computer failure. They were prepared a week prior to the patient attending. Following the pre-assessment clinic, any medical condition, medicines or allergies were highlighted as part of the individualised risk assessment process prior to surgery.

Following discharge, records were stored in cabinets in a locked room and then couriered to off site storage.

Between May 2021 and April 2022, there were six records audits carried out. Target compliance was 95%. If this was not achieved the audit was repeated the following month. For two audits, results were 90.7% and 94.1%. We were shared an action plan; this showed that all actions had been completed and there was improvement to 98.7% and 98.9% for the re-audits. There was an average compliance of 96.3%.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely.

The provider had an up to date medicines management and administration policy and standard operating procedure for staff to follow to minimise medicines errors.

There was a separate policy for the safe management of cytotoxic medications. Cytotoxic medications are hazardous to health and are described as a group of medicines that contain chemicals which are toxic to cells, preventing their replication or growth. We saw the policy had recently been reviewed through the organisations ratification committee.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

Good

Outpatients

Nursing staff that administered eye drop medicines underwent competency training and assessment prior to administering medicines. Patients were given information on 'to take home' medicines as part of their discharge consultation.

Staff completed medicines records accurately and kept them up to date. Staff were required to complete medicines management awareness training. There was 95.7% compliance with one staff member in the process of completion.

The provider carried out medicine prescribing and administration audits. From May 2021 to April 2022, four audits were completed. Average compliance rate was 92%. This was below the provider target of 95%. We saw an improvement had been made in the most recent audit with a compliance rate of 99%.

Staff stored and managed all medicines and prescribing documents safely. All medicines were stored in rooms accessible only to staff in locked cupboards. Medicine stocks we checked were labelled and in date.

Fridge temperatures were checked, recorded appropriately and attached to an electronic system that alerted staff if the temperature was out of range. All medicines we checked requiring cold storage were labelled and in date.

The service completed medicines management audits. We saw all actions had been completed.

There was a service level agreement with a local pharmacy. The pharmacy provided the supply and disposal of medicines. Staff told us they could contact the pharmacy service for advice and support if needed. The external pharmacy contractor also carried out an audit of medicines stocks at the hospital every three months.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff raised concerns and reported incidents and near misses in line with the organisations policy.

Staff knew what incidents to report and how to report them. The organisation used an electronic reporting system to report and record any incidents. How to log an incident on the system was part of mandatory training requirements. At the time of inspection 22 (95.7%) of 23 staff had completed this course.

New incidents were discussed at daily hospital-wide huddles at the start of each day. The senior managers reviewed all new incidents on a daily basis to identify any serious incidents that required immediate actions, such as escalation to the corporate provider or external reporting to organisations such as the Care Quality Commission or NHS service commissioners.

In the previous 12 months to May 2022, there had been a total of 187 reported incidents. Of these, 52 (27.9%) related to care and treatment in the outpatient department.

Good

Outpatients

The service had not reported any never events in the previous 12 month period. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Managers shared learning with their staff about never events that had occurred at other organisation locations. Staff reported serious incidents clearly and in line with trust policy. The service used a root, cause analysis (RCA) approach to investigate serious incidents.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if things went wrong.

There was a 'sharing lessons' bulletin that was shared with staff about incidents that had occurred across the locations. There was evidence that changes had been made as a result of feedback.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

We reviewed three root cause analysis investigation reports following incidents at the service. We observed changes that had been implemented as a result of previous organisation incidents.

There was a policy and process for the management of national safety alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) and the Central Alerting System (CAS). The director of clinical services and clinical governance lead received them and cascaded to the appropriate hospitals or departmental managers.

Are Outpatients effective?

Inspected but not rated

We did not rate effective.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality holistic care according to best practice and national guidance. We reviewed a sample of policies and guidelines and found that all were within their dates of review and complete.

The service used standardised pathways for the delivery of care. For example, the cataract pathway. The pathway included the procedures to follow for referral booking, through to post-operative review in the community. This ensured the whole patient journey was planned from start to end.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

At staff huddles, staff routinely referred to the psychological and emotional needs of patients. Patients' needs were assessed individually to ensure appropriate care and treatment was provided.

Good

Outpatients

Changes to clinical practice, national guidance and policies were reviewed and developed centrally by the corporate provider and cascaded to the hospital and shared with staff. Policies based on best practice and clinical guidelines were developed nationally and cascaded to the hospitals for implementation. We saw evidence that changes in practice and guidance updates were routinely discussed as part of routine clinical governance and medical advisory committee meetings.

Nutrition and hydration

There were drinks and biscuits available to patients attending for preoperative consultation appointments in the waiting area. This was well stocked and easily available.

Patient outcomes

Staff were actively engaged in activities to monitor and improve the effectiveness of care and treatment. They used the findings to make improvements and achieved consistently good outcomes for patients. Opportunities to participate in national benchmarking were proactively pursued.

The service participated in relevant national clinical audits for ophthalmology. Outcomes for patients were positive, consistent and met expectations, such as national standards.

The service submitted data to PROMS. (PROMS is patient reported outcome measures). This is a tool used to capture patient reports of their outcomes following surgery. We reviewed the PROMS data in relation to the multifocal artificial lens exchange and refractive lens exchange measures for 2021. Patients scored the service 100% in five out 10 of the measures.

These included 100% of patients reporting they were satisfied with the results and would recommend the treatment to friends and family.

The hospital submitted data to the Private Healthcare Information Network (PHIN). This is an independent, government-mandated source of information about private healthcare which supports patients to make better-informed choices of care provider. PHIN data did not identify any concerns in relation to his service.

Managers shared and made sure staff understood information from the audits. Information was shared through newsletters, noticeboards and team meetings.

Pre assessment audits were carried out weekly to ensure all patients booked for theatre had a complete set of records and test for their planned surgery. Any missing records were passed to the Pre-assessment team to complete.

The location was benchmarked internally against other locations for the organisation and externally with other NHS organisations providing cataract care.

The organisation was a member of the General Optical Council with qualified optometrists employed.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. We saw there was an audit programme in place which included environmental checks, records and medicines.

Good

Outpatients

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. The service recognised the importance of continuing development of staff skill, competence and knowledge as integral to ensuring safe care.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work. Staff were buddied up with a senior member of staff for support. The induction included all staff, spending time in another Optegra hospital in order to gain an understanding of the patient experience and journey through the hospital. This included non-clinical staff who worked in the organisation's contact centre.

Staff underwent a probationary period with regular meetings to support staff and review performance. They completed a new starter pack with the necessary competencies and assessments included.

Staff were proactively supported and encouraged to acquire new skills, use their transferable skills, and share best practice.

There was access to a practice education facilitator (PEF) from a local NHS trust to support student nurses with their learning needs.

Managers supported staff to develop through yearly, constructive appraisals of their work. All staff we spoke with reported they had participated in an appraisal in the past 12 months.

Data provided by the service showed 87% of all hospital staff at the time of inspection had received an annual appraisal. Following the inspection, the provider confirmed that all staff had now received an appraisal.

A dedicated training team supported and monitored the learning and development needs of staff. They attended the location to support with one to one training and assessments. All training and competencies were standardised across the organisation. The service monitored the competencies achieved with a requirement to re assess every three years.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Consultants working under practicing privileges were required to submit evidence of their clinical appraisal annually from their substantive employer (such as the NHS trusts) and this was reviewed as part of the practicing privileges processes. Where consultants did not have substantive employment within the NHS, the provider arranged for their appraisal to be completed by a designated responsible officer.

Staff told us they had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role. Staff were required to complete competencies applicable to their role prior to working independently.

Managers identified poor staff performance promptly and supported staff to improve.

Multidisciplinary working

Surgeons, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

There was effective daily communication between multidisciplinary teams within the hospital. Nursing and healthcare staff told us they had a good relationship with the optometrists and ophthalmologists. At the beginning of each surgery day, the team completed a team brief (huddle) to discuss patient safety and individual staff roles and responsibilities.

There was regular communication between the day surgery manager, outpatient's manager and the bookings teams so patient care could be coordinated and delivered effectively.

Staff worked with other agencies when required to care for patients such as community optometrists, district nurses and local clinical commissioning groups (CCG).

Patients were followed up either in the hospital or by a community optometrist four weeks following surgery where the outcome of the surgery was discussed with the patient.

The service liaised with local GP's and optometrists. Ensuring they received copies of the discharge letters for community follow up.

Seven-day services

The location was open Monday to Friday between 7.00am and 7.00pm. There was additional opening on Saturdays depending on the needs of the patients waiting.

Outside of normal working hours, there was an out of hours on call service. There were teams of staff allocated on a rota system in case of an ophthalmic emergency. There was also a senior manager on call rota to support hospital staff.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The hospital offered limited health promotion advice due to the specific and specialist nature of the treatments provided.

Staff told us they offered verbal advice and information leaflets relating to the eye procedures and discussed lifestyle choices relating to their vision needs as part of the initial consultation process. Information was also available on the provider's website.

Good

Outpatients

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Mental capacity and deprivation of liberties was a training course as part of training requirements. The training matrix provided by the service showed that 94% of staff had completed this training.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. If a patient was assessed as lacking capacity to consent, an alternative consent form was used where a family member with Lasting Power of Attorney could provide consent.

Staff made sure patients consented to treatment based on all the information available. Interpreters or signers could be booked for consent purposes if needed.

Staff clearly recorded consent in the patients' records.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and they knew who to contact for advice.

Staff could describe and could access the policy for accurate advice on the Mental Capacity Act. Dementia awareness was part of annual mandatory training requirements; this included Mental Capacity Act 2005.

There was a minimum of seven days 'cooling off' period from the initial signed consent to the day of surgery, in line with the Royal College of Ophthalmologists guidance (updated December 2021).

Consent was recorded in the patients' records. We looked at six patient records. These showed that written consent had been obtained from patients and that planned care was delivered with their agreement. Consent forms showed the risks and benefits were discussed with the patient prior to carrying out eye surgery procedures.

Consent was confirmed again immediately prior to the treatment by the treating clinician to confirm that the patient still wanted to proceed with treatment.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

Consent to share copies of the discharge letter post-surgery, with the patient's GP and community optometrist was obtained along with consent for surgery.

Between May 2021 and April 2022, quarterly consent audits were carried out. All results were above the target of 95%, with an average compliance of 99.3%.

Are Outpatients caring?

Good

Outpatients

Good

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

We observed good interactions between all staff and patients. They were welcomed into the building and spoken to in a way that put them at ease.

Patients said staff treated them well and with kindness.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Patients were routinely asked before discharge to give feedback on their experience and this was documented in the patient record.

The friends and family survey results for August 2021 to May 2022 showed almost 100% of patients rated the service as very good or good. The patient feedback received was very positive in relation to the care they received, and the number of responses received was high, with up to 1300 responses per month during this period.

The service collated patient feedback to update the staff. We reviewed the April 2022 update and found it contained all the positives and any areas where improvement was needed and the action points.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it.

We observed staff putting patients at their ease particularly when they expressed feeling anxious.

Good

Outpatients

There were chaperone posters displayed for patients who needed support. Doors to clinic rooms included signage to indicate if the room was occupied to prevent disturbance.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff we spoke with were clear about how the treatments resulted in positive outcomes for patients both physically and emotionally.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. If patients were unable to consent to treatment independently, those close to them could support them.

Staff talked with patients in a way they could understand. For patients, identified as vulnerable, someone close could remain with them.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Staff supported patients to make informed decisions about their care.

Patients gave positive feedback about the service.

Are Outpatients responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The service was commissioned by the NHS to provide cataract surgery and age-related macular degeneration (AMD) treatments for the local adult population on a day case basis.

The hospital also provided a range of procedures for private fee paying patients, such as refractive laser eye surgery, lens exchange surgery and intraocular lens implant procedures. All treatments were provided for adult patients only. The registered manager and the hospital manager reported that 80% of surgical procedures were for NHS patients.

The provider's centralised bookings teams managed the patient referrals on an electronic patient administration system. Patients were required to attend for a pre-assessment clinic to ensure they were suitable for surgery. A date for surgery was given to the patient prior to leaving.

Good

Outpatients

Facilities and premises were appropriate for the services being delivered. The hospital had two theatres and a 12-bedded day case area, which was split into six day case beds per theatre. Each cubicle was segregated to maintain privacy and dignity. The hospital did not provide inpatient accommodation.

The service had sufficient capacity to meet the needs of the patients they saw. All patients were booked in advance so services and appropriate staffing could be planned prior to patients attending their appointment.

Patients were assessed for suitability for surgery via telephone prior to their diagnostic visit. Following their diagnostic visit they were sent a date for their surgery.

Managers monitored and took action to minimise missed appointments. Patients were contacted prior to surgery to confirm the appointment. We saw this was part of the clinical pathway for treatment.

Meeting people's individual needs

The service was inclusive and proactively took account of patients' individual needs and preferences. Staff gave careful consideration to make reasonable adjustments to help patients access services. They coordinated care with other services and organisations.

The service had a standard operating procedure to ensure they met the national accessibility requirements. Any requirements a patient required was documented on both the patient administration and clinical administration system and in the paper records.

Each patient was individually assessed at the pre assessment clinic. Any patient identified with reduced mobility or communication concerns had their needs assessed, recorded on the electronic patient record and a plan made to address any issues identified as necessary.

There was an equality policy that included the management of patients with a disability. This included an individualised risk assessment approach to assess and plan care in the best interests of the patient.

There was a proactive approach to understanding the needs and preferences of different groups of people and to delivering care in a way that meets these needs, which was accessible and promoted equality. This included people with protected characteristics under the Equality Act, and people who were in vulnerable circumstances or who had complex needs.

The service had information leaflets available in languages spoken by the patients and local community. There were also videos available that patients could view. Leaflets, about the procedures, were available in languages other than English and in larger fonts.

Managers made sure patients could get help from interpreters when needed. The service utilised an interpreter service if needed for patients whose first language was not English.

Toilets were accessible for patients with mobility needs.

Hearing loops were available for patients with a hearing impairment. Sign language interpreters could be booked if needed for support.

Records showed 94% of staff had completed dementia awareness training. For patients living with a learning disability or autistic spectrum disorder, they were offered additional visits, with those close to them, to help with preparations or scheduling their procedure to be carried out at the start or end of the theatre list.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Patients accessed the services through a number of routes, such as referral to the central booking team via their GP, optician or NHS Trust, as well as through self-referral. When a patient made an initial enquiry about the services offered at the hospital, an initial consultation appointment was made and they were given verbal and written information about the types of treatments offered.

Patients were then reviewed by an optometrist or ophthalmologist before treatment. As part of this consultation, a review of the patient's medical history was carried out to determine whether they were suitable to undergo treatment at the hospital. The ophthalmologist saw each patient on the day of surgery to check if there had been any changes to their health, personal circumstances and to confirm patient consent for treatment.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The service collated monthly performance information on referral to initial consultation and referral to treatment for NHS cataract and age-related macular degeneration (AMD) patients.

Records showed the average monthly referral to treatment wait times for NHS cataract patients had been over 13 weeks between June 2021 and October 2021. However, this had consistently improved each month to just over six weeks between February 2022 and April 2022. The hospital reported average wait times of 4.8 weeks during the latest month (May 2022).

The average monthly referral to treatment wait times for NHS AMD patients ranged between 1.2 and two weeks between June 2021 and May 2022.

The hospital manager told us they did not have a performance target for referral to treatment waiting time for privately funded patients (such as those requiring laser eye surgery) because appointment dates were based on patient's own preferences. The hospital manager confirmed most privately funded patients underwent surgery within approximately four weeks of their initial consultation.

The patients we spoke with and patient records we looked at also showed patients did not experience long waits from referral to treatment.

Patients were given staggered appointment times during the day so they did not experience long waits

The service monitored the number of patients that did not attend their consultation to ensure they could be appropriately followed up and referred to their GP if necessary. In the 12 months from May 2021 to April 2022 the service reported 6.4% of patients did not attend an appointment.

Good

Outpatients

The service reported that cancelling appointments were rare. This was due to having multiskilled staff supplemented by bank and agency staff. In the 12 months from May 2021 to April 2022 the service only cancelled 3.4% of booked appointments.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas.

In the previous 12 months to May 2022, there had been a total of 12 reported complaints. Of these, 6 related to the outpatient department.

The service aimed to respond to a complaint within two days and provide a full response to the complaint within 20 days. Complaints we reviewed were responded to within these timeframes.

Staff understood the policy on complaints and knew how to handle them. All complaints were investigated in line with the company complaints policy and discussed within hospital and department team meetings.

Staff were trained in how to support patients to make a complaint. Conflict resolution was a module included in the statutory and mandatory training.

If patients were still not satisfied, they were given information on how to escalate their complaint to external organisations such as the Parliamentary and Health Service Ombudsman (for NHS patients) and the Independent Sector Complaints Adjudication Service (ISCAS) for private funded patients.

Feedback from compliments and complaints was routinely disseminated to all staff through the use of a monthly newsletter.

Are Outpatients well-led?

Good

Our rating of well-led improved. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The overall responsibility for the hospital was with the registered manager, who was also the regional head of clinical services. The registered manager also had responsibility for another of the provider's hospitals.

Good

Outpatients

The day to day running of the hospital was managed by the hospital manager, who reported to the regional director. The hospital manager was supported by the day surgery manager, outpatients department manager, the administrative team manager and the optometrist team manager. The day surgery manager was responsible for managing the day case and theatre areas.

The managers had the relevant skills and abilities to manage the surgical services effectively. They understood the risks to the services and had clear oversight on patient safety, governance and performance issues through daily involvement and quality monitoring.

A daily safety and quality huddle (QASH) took place at the start of each day. This was attended by the senior management team and heads of department. There were also daily safety huddles and team briefings in the day case and theatre areas so that staff received all relevant information.

The nursing, support and medical staff we spoke with told us they understood the reporting structures clearly and described their line managers as approachable, visible and who provided good support.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services.

The provider's mission statement was 'to be the most trusted eye care provider'.

This was underpinned by a set of four values; 'we are safe', 'we are focussed', 'we move fast' and 'we are brave'.

The hospital's clinical game plan 2022 outlined the hospital's strategy and objectives for the current year. This included specific clinical and workforce objectives, such as improving incidents, medicines management, infection control and resuscitation processes and development of staff training plans and leadership development.

Progress against key objectives was monitored and reported as part of routine clinical governance meetings and medical advisory committee meetings.

The mission statement, values and strategic objectives were clearly displayed on notice boards across the day case and theatre areas. They had been cascaded to staff across the services and the staff we spoke with had a good understanding of these. Objectives were also incorporated into individual staff appraisals.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

The organisation was committed to the patient's experience being positive during their care and treatment.

All staff we spoke with enjoyed working at the location and for the organisation. There was good teamwork across all staff roles, and we were shared examples of staff supporting each other.

There was a freedom to speak up guardian to support staff in raising issues or complaints regarding the service. There had been no concerns raised with the freedom to speak up during the past 12 months.

Staff we spoke with reported they thought it was a safe place to work, there was always someone to discuss problems with and everyone was approachable.

The organisation supported staff to progress within the organisation and increase their competencies. Senior managers told us the results of the staff survey had been shared. They identified a theme related specifically to health care technicians that was being addressed by the senior team.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were clear governance structures in place that provided assurance of oversight and performance against safety measures.

The hospital participated in medical advisory committee (MAC) meetings every three months led by the MAC chair. The MAC meetings were attended by the site management team and surgical specialty lead consultants. Recent meeting minutes showed the MAC undertook reviews of new and updated guidance, consultants' performance, practicing privileges reviews as well as a review of governance and key risks.

The hospital held clinical governance meetings every three months and were attended by the senior managers and departmental leads. Meeting minutes from October 2021 to April 2022 showed discussions took place around performance and quality, governance, incidents, complaints and audit performance.

There were a number of groups and committees in place that held meetings either monthly or every three months and reported to the senior management team. This included the medicines management committee, resuscitation meeting, infection prevention and control meeting, age-related macular degeneration (AMD) team meetings, staff training meetings and clinical staff meetings.

Each meeting had standardised agenda and action logs to monitor improvements to the services. We looked at a range of meeting minutes from September 2021 to May 2022 these showed discussions around incidents, complaints, audits, performance, risks and changes to guidance were routinely discussed as part of these meetings. Meeting minutes showed action plans were in place and these were followed up at subsequent meetings.

There was regular communication and oversight from the corporate provider. The senior management team and departmental leads routinely reported governance, performance and risks to the corporate provider. The senior managers and departmental managers participated in regular peer meetings to share learning and benchmarking with the provider's other hospitals.

The site management team carried out daily and weekly informal meetings to review key risks and performance. The senior managers also held daily and weekly informal meetings to discuss day to day issues. There were daily huddles held in the day case and theatre areas and a hospital-wide quality and safety huddle (QASH) was held daily to manage patient risks and cascade governance information to staff.

Practising privileges were routinely reviewed and authorised by the hospital director, director of clinical services and the MAC chair and were also reviewed at the medical advisory committee.

The hospital reported there were no outstanding queries relating to practising privileges.

We looked at the records for two consultants who worked across both the surgical and outpatient services. These contained up to date appraisal records, General Medical Council (GMC) revalidation, indemnity certificates and Disclosure and Barring Service (DBS) checks.

We also spoke with two surgical consultants, who told us practising privileges were reviewed annually and they were required to submit updated appraisals, GMC registration information and indemnity insurance information to the hospital on an annual basis. The hospital director told us any individuals working under practising privileges received reminders to submit required documentation annually and individuals who did not submit the required information within required timelines would have their practising privileges removed or suspended.

The service had a centralised human resources team that monitored compliance with the Fit and Proper Person Requirement (FPPR) of the Health and Social Care Act. This regulation ensures that leaders have the essential skills and competencies to manage an organisation. We looked at the recruitment records for the hospital manager and the registered manager (also the regional head of clinical services and found appropriate checks had been carried out in line FPPR requirements.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The key risks relating to the services were incorporated into the hospital wide risk register. The risk register showed that key risks were identified, and control measures were put in place to mitigate risks. Risks had a review date and an accountable staff member responsible for managing that risk.

Staff were aware of how to record and escalate key risks on the risk register. A risk scoring system was used to identify and escalate key risks to the senior management team and to the corporate provider.

Key risks and risk register entries were reviewed at routine clinical governance, medical advisory committee and senior management team meetings.

Routine staff meetings took place to discuss day-to-day issues and to share information on performance, complaints, incidents and audit results.

We saw that routine audit and monitoring of key processes took place to monitor performance against patient safety standards and organisational objectives. There was a structured programme of audit covering key processes such as infection control, patient records, surgical safety and medicines management. Records showed staff achieved good levels of compliance across most audits over the past 12 months.

Good

Outpatients

Information relating to performance against key quality, safety and performance objectives was monitored and cascaded to staff through routine team meetings, safety huddles, performance dashboards and newsletters. Audit findings were also reviewed at routine departmental and hospital-wide meetings and monitored centrally by the corporate provider to look for improvements to the service.

The provider had developed a 'caring, responsive, effective, well-led and safe' (CREWS) accreditation programme which involved a visit by the corporate provider governance team to assess compliance against the Care Quality Commission's standards every three months. The most recent CREWS accreditation visit took place during May 22 and the hospital achieved a score of 87%. The registered manager and the hospital manager reported this was among the highest scores achieved across the provider's hospital locations

The organisation had developed a clinical game plan. The plan set out how the organisation would deliver excellent clinical standards. The plan set out the priorities and measures required to achieve the goals.

The service produced newsletters to keep staff informed of performance relating to the service. We saw that this included, compliments, incidents, complaints, audit results and current risks.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The organisation had an electronic system that included a 'live dashboard' of performance across the locations. The performance data was collated, stored, and reviewed in real time within the electronic system. Referral data, governance and cancelation data were included within the system.

Senior managers analysed the data in the dashboard to benchmark across locations and make improvements where needed.

Patient records were a combination of paper and electronic that were managed well. In the event of computer failure, essential information could initially be captured on paper.

Organisational policies and guidelines were stored in the electronic system. Staff were allocated individual login details to access information and ensured information was not visible when left unattended. There was a requirement for staff to read, when updated. The system monitored the time staff accessed the policies.

There was a process to submit statutory notifications to the CQC and we received a notification following an incident.

The statutory and mandatory training included modules on data security awareness and data protection.

Staff completed General Data Protection Regulation (GDPR) training as part of their mandatory training. Training compliance across the hospital was 98.1%, indicating most staff had completed this training.

We did not identify any concerns in relation to the security of patient records during the inspection. Paper-based patient notes and staff records were kept securely. Records such as such as staff recruitment records, audit records and staff rotas were held electronically.

The corporate group operations director was the data protection lead for the service. The hospital reported there had been no data breaches that were reportable to the Information Commissioner's Office (ICO) in the past 12 months.

Computers were available across the service and staff access was password protected. Staff we spoke with did not identify any concerns relating to accessing IT systems or any connectivity issues.

There were several notice boards across the hospital that displayed information such as audit and survey results, safety bulletins, meeting minutes, quality and performance dashboards, patient safety and infection control information.

Staff could access policies, procedures and clinical guidelines through the provider's electronic systems. Staff told us they could access patient information and up to date national best practice guidelines and prescribing formularies when needed.

Engagement

Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Staff told us they received good support and regular communication from the local management team and the wider organisation. Staff at the hospital routinely participated in hospital-level and team meetings and participated in regular meetings with peers across the provider's other locations. Staff engagement also took place through emails, daily huddles, newsletters and through other general information and correspondence that was displayed on notice boards.

The service carried out an annual staff survey to gain feedback from staff about their experiences. The survey consisted of six indicators; process, engagement, structure, strategy, team environment and leadership.

The most recent hospital-wide staff survey (2021/22) showed staff responses were positive around the six indicators, indicating staff were very positive about the support they received from the local management team

Staff working at the hospital could access additional support, such as counselling or emotional support through the corporate provider's occupational health team if needed.

Staff told us they routinely engaged with patients to seek feedback about the quality of the service provided. This was done through informal daily engagement and through feedback surveys. The findings from the friend and family survey showed patient feedback was very positive in relation to the care they received.

Staff reviewed patient survey feedback to look for improvements to the service. The service had recently moved staff parking offsite to increase patient car parking facilities following feedback from patients during recent surveys.

The registered manager and the hospital manager told us they routinely engaged with the public to promote services through the provider's website, through local events and through the use of social media. The hospital had also implemented a patient focus group to enable patient engagement.

Good

Outpatients

Staff routinely engaged with other healthcare professional (such as GP's) involved in their care and treatment. Staff also held routine engagement meetings with local commissioners regarding performance around care and treatment provided for NHS patients.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

The culture across the services was based on innovation, learning and quality improvement. We found significant improvements had been made since our last inspection in July 2017. We also identified improvements in performance such as for referral and treatment waiting times for NHS cataract patients.

The hospital was committed to providing a service that was continually evolving and improving as a result of learning or research.

The hospital's clinicians and the eye services division were involved in a number of clinical research projects. This included clinical studies for use of novel intravitreal (eye injection) medicines for AMD patients and a study to review clinical and patient reported outcomes of post laser vision correction patients implanted with an extended depth of focus.

The hospital was involved in a study to report on the clinical outcomes of elective intraocular lens surgery in patients with high ametropia (blurred vision). The hospital also ran a project to look at patient satisfaction with a nurse led injector service delivery.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.